MEDICAID EXPANSION
UNDER THE AFFORDABLE CARE ACT

DECEMBER 2010

WHAT IMPACTS WILL THE AFFORDABLE CARE ACT HAVE ON IOWA MEDICAID?

The Affordable Care Act was signed into law on March 23, 2010. The law is complex and requires many changes for Iowa Medicaid. The law requires "maintenance of effort" which means that all states are prohibited from reducing or restricting current eligibility rules until 2014. The Affordable Care Act requires development of Health Benefits Exchanges for individuals to purchase insurance, apply and enroll for benefits such as Medicaid and tax subsidies. And the law requires an expansion of Medicaid to cover certain individuals with income up to 133% Federal Poverty Level through a streamlined eligibility process.

WHO WILL BE COVERED UNDER THE MEDICAID EXPANSION?

The Affordable Care Act is expected to increase Medicaid enrollment in Iowa by 25% or by 80,000 to 100,000 Iowans in 2014. The ACA will eliminate coverage based on categories and mandates Medicaid coverage for all people whose income is at or below 133% Federal Poverty Level. This equates to $14,412 for an individual or $29,328 per year for a family of four. In 2014 individuals between age 20 and 64 (who are not pregnant or disabled) with incomes at or below 133% Federal Poverty Level will be covered. This effectively streamlines the current system of complex categories.

HealthCare.gov

For more information on the Affordable Care Act, visit;

www.healthcare.gov

HOW WILL MEDICAID ENROLLMENT BE SIMPLIFIED?

Medicaid eligibility and enrollment will be integrated with the Health Benefit Exchange. This will allow individuals to apply for, enroll in and renew their enrollment in Medicaid through a website. This will require one common application for Medicaid, CHIP and premium assistance tax credits. The Affordable Care Act provides states the options to allow community partners (such as hospitals) to make presumptive Medicaid eligibility determinations.

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WHAT ARE THE REQUIREMENTS FOR MEDICAID EXPANSION AND HOW WILL THE EXPANSION GROUP BE FUNDED?

The Affordable Care Act mandates a number of changes to streamline eligibility and restructures how Medicaid eligibility is determined. A Modified Adjusted Gross Income (MAGI) calculation will be used, which will require the use of automated verification of income from the Internal Revenue Service (IRS). States must still determine an individual's income as of when the application is processed. Use of income disregards will be prohibited. No asset or resource tests can be used.

Enhanced Federal funding will be available to finance the "newly eligible" as follows;

- 100% for three years from 2014-2016
- 95% federal funds in 2017
- 94% federal funds in 2018
- 93% federal funds in 2019
- 90% federal funds in 2020 and beyond

Prepared by the Health Benefits Exchange Interagency Workgroup
http://www.idph.state.ia.us/hcr_committees/health_benefit_exchange.asp

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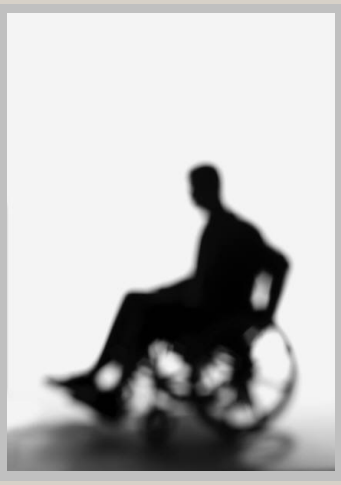

ARE ANY MEDICAID GROUPS NOT IMPACTED BY THE NEW ELIGIBILITY REQUIREMENTS?

The following groups are excluded from the MAGI calculation and the current income disregard and asset test will continue to apply:

- People eligible for Medicaid through another program (SSI and foster care)
- Age 65 and older
- Blind or Disabled
- Medically Needy
- Medicare Savings Plans
- Long term care (including nursing facility and level of care in any institution equivalent to a nursing facility, home or community-based services under a waiver)

WHAT BENEFITS WILL BE AVAILABLE TO THE EXPANSION GROUP?

The Benchmark Benefits Package must include mental health parity and include at least the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral treatment
- Prescription Drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
- Family Planning Services

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